2008 Fallon Senior Plan Premier

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services/Prescription Drug Coverage as a Member of Fallon Community Health Plan

January 1 – December 31, 2008

This booklet gives the details about your Medicare health and prescription drug coverage and explains how to get the prescription drug and health care you need. This booklet is an important legal document. Please keep it in a safe place.

Fallon Community Health Plan Customer Service:
For help or information, please call Customer Services or go to our Plan Web site at www.fchp.org.

1-800-868-5200 (Calls to these numbers are free)
TTY users call: 1-877-608-7677

Hours of Operation: 8 a.m. to 8 p.m., seven days a week

08-670-514a
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Contact Information

Telephone numbers and other information for reference

How to contact our Plan Customer Service

If you have any questions or concerns, please call or write to our Plan Customer Service. We will be happy to help you. Our business hours are from 8 a.m. to 8 p.m., seven days a week. If you call outside of these hours, please leave a message including your name, number and the time you called. A representative will return your call no later than one business day after you leave the message.

CALL	1-800-866-5200. This number is also on the cover of this booklet for easy reference. Calls to this number are free.
TTY	1-877-608-7677. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.
FAX	1-508-368-9966
WRITE	Fallon Community Health Plan 10 Chestnut St. Worcester, MA 01608
VISIT	Fallon Community Health Plan 10 Chestnut St. Worcester, MA 01608
WEBSITE	www.fchp.org

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals

Part C Organization Determinations

CALL 1-800-866-5200. Calls to this number are free.

TTY 1-877-608-7677. This number requires special telephone equipment. Calls to this number are free.

FAX 1-508-755-7393 for regular organization determinations.
1-508-368-9133 for "fast" organization determinations.

WRITE Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

For information about Part C organization determinations, see section 9.

Part C and Part D Grievances

CALL 1-800-868-5200. Calls to this number are free.

TTY 1-877-608-7677. This number requires special telephone equipment. Calls to this number are free.

FAX 1-508-755-7393

WRITE Fallon Community Health Plan
Member Relations Department
10 Chestnut St.
Worcester, MA 01608

For information about Part C grievances, see section 8. For information about Part D grievances, see section 10.

Part C and Part D Appeals

CALL 1-508-368-9950, if it is a "fast appeal." You also may call
1-800-868-5200, if it is a "fast appeal." Calls to this number are free.

TTY 1-877-608-7677. This number requires special telephone equipment. Calls to this number are free.

FAX 1-508-755-7393

WRITE Fallon Community Health Plan
Member Relations Department
10 Chestnut St.
Worcester, MA 01608

For information about Part C appeals, see section 9. For information about Part D appeals, see section 10.

Part D Coverage Determinations

CALL 1-800-868-5200. Calls to this number are free.

TTY 1-877-608-7677. This number requires special telephone equipment. Calls to this number are free.

FAX 1-508-755-7393

WRITE Fallon Community Health Plan
Pharmacy Services Department
10 Chestnut St.
Worcester, MA 01608

For information about Part D coverage determinations, see section 10.

The SHINE Program – a state program that gives free local health insurance counseling to people with Medicare

The SHINE Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. The SHINE Program can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. The SHINE Program has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan for the first time. See Section 2 for more information about your Medigap guarantee issue rights.

You may contact the SHINE Program at:

SHINE Program
Executive Office of Elder Affairs
One Ashburton Place
Boston, MA 02108
Telephone: 1-800-243-4636 (TTY: 1-800-872-0166).

You may also find the Web site for the SHINE Program at www.medicare.gov on the Web. Under "Search Tools," select "Helpful Phone Numbers and Websites."

Masspro – a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 8, 9 and 10 for more information about complaints, appeals and grievances.

You may contact Masspro at:

Masspro
245 Winter St.
Waltham, MA 02451
Telephone: 1-800-252-5533 (TTY: 1-877-486-2048)

How to contact the Medicare program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government Web site for Medicare information**.** This Web site gives you up-to-date information about. Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search

Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Other organizations (including Social Security and Medicaid, a state government agency that handles health care programs for people with limited resources)

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

MassHealth
600 Washington St.
Boston, MA 02111
Telephone: 1-800-841-2900 (TTY: 1-800-497-4648)

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit **www.ssa.gov** on the Web.

Prescription Advantage – an organization in your state that provides financial help for prescription drugs

Prescription Advantage is a state organization that provide limited -income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact Prescription Advantage at PO Box 15153, Worcester, MA 01615-0153, or 1-800-243-4636 (TTY: 1-877-610-0241). Their Customer Service Representatives are available to answer your questions Monday through Friday, 9 a.m. to 5 p.m. You can also find the Web site for Prescription Advantage at www.800ageinfo.com.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 1-312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or “Group”) Coverage

If you or your spouse get your benefits from your current or former employer or union, or from your spouse’s current or former employer or union, call your employer’s or union’s benefits administrator or Customer Service if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season.

Welcome to Fallon Senior Plan Premier!

We are pleased that you've chosen our Plan.

Fallon Senior Plan Premier is an HMO, or **H**ealth **M**aintenance **O**rganization.

Thank you for your membership in Fallon Senior Plan Premier; you are getting your health care and Medicare prescription drug coverage through our Plan. Fallon Senior Plan Premier is not a "Medigap" Medicare Supplement Insurance policy.

Throughout the remainder of this Evidence of Coverage, we refer to Fallon Senior Plan Premier as "Plan" or "our Plan."

This Evidence of Coverage explains how to get your health care and drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders (including optional supplemental benefit brochures), Annual Notice of Change (ANOC), formulary, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. The information in this Evidence of Coverage is in effect for the time period from January 1, 2008 - December 31, 2008.

You are still covered by Medicare, but you are getting your Medicare services as a member of our Plan.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get the care you need or your prescriptions filled including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.
- How to leave our Plan, and other Medicare options that are available including your options for continuing Medicare prescription drug coverage.

If you need this Evidence of Coverage in a different format (such as in large print), please call us so we can send you a copy.

Eligibility Requirements

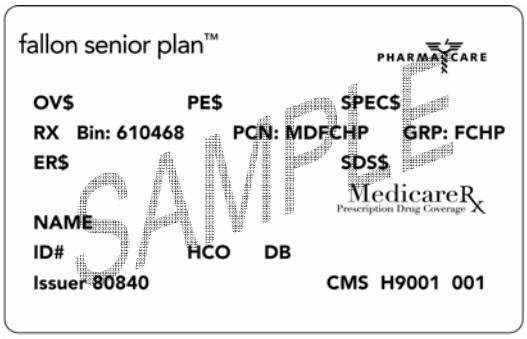
To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

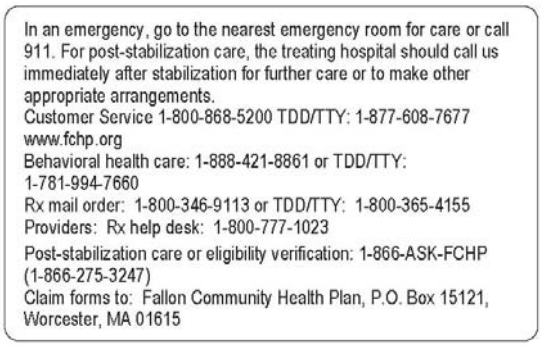
Use your plan membership card, not your red, white, and blue Medicare card

Now that you are a member of our Plan, you must use our membership card for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our Plan and using our Plan services, you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services, items and drugs**.** (See Section 4 for information on Part D prescription coverage and Section 3 for information on covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items and drugs. If your membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Here is a sample card to show you what it looks like:





Field key:
OV = Office visit copay
PE = Physical exam copay
SPEC = Specialist visit copay
Rx = Y or N indicator for rx coverage
ER = Emergency room copay
SDS = Same-day surgery copay
HCO = Internal code (physician code)
DB = Dental indicator

The Provider Directory gives you a list of plan providers

Except in emergencies, certain urgently needed services, and out of the area dialysis services, you must use plan providers in order for services to be covered.

Every year, as long as you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of our Plan providers.

If you don't have the Provider Directory, you can get a copy from Customer Service. Contact information is located in Section 1 of this booklet. You may ask Customer Service for more information about our Plan providers, including their qualifications and experience. Customer Service can give you the most up-to-date information about changes in our Plan providers and about which ones are accepting new patients. A complete list of plan providers is available on our Web site at www.fchp.org.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a Fallon Senior Plan Provider Network directory, which gives you a list of our network pharmacies, at least every three years, and an update of our Pharmacy directory every year that we don't send you a complete Pharmacy Directory. You can use it to find the network pharmacy closest to you. If you don't have the Fallon Senior Plan Provider Network directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits that we provide.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
Information about how to request an exception and appeal our coverage decisions;
A description of changes to the formulary affecting the prescriptions you have gotten filled that will occur at least 60 days in the future;
A summary of your coverage this year, including information about:

- **Amount Paid For Prescriptions-**the amounts paid that count towards your initial coverage limit.
- **Total Out-Of-Pocket Costs That Count Toward Catastrophic Coverage-** The total amount you and/or others have spent on prescription drugs that count towards your qualifying for catastrophic coverage. This total includes the amounts spent for your co-payments, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

What should you do if you don't get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

How do I keep my member record up to date?

We have a member record about you as a plan member. Doctors, hospitals, pharmacists, and other plan providers use your member record to know what services or drugs are covered for you. Your member record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage, the Primary Care Physician you chose when you enrolled, and other information. Section 6 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Customer Service know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident. Call Customer Service at the number in section 1 of this booklet.

The geographic service area for our Plan.

The counties and parts of counties in our service area are listed below.

The Fallon Senior Plan Premier service area includes all of Worcester County and parts of the following counties:

Franklin County, the following ZIP codes only:

Erving	01344	Warwick	01378
New Salem	01355	Wendell	01379
North New Salem	01364	Wendell Depot	01380
Orange	01364		

Hampden County, the following ZIP codes only:

Bondsville	01009	Palmer	01069
Brimfield	01010	Thorndike	01079
Holland	01521	Three Rivers	01080
Monson	01057	Wales	01081

Hampshire County, the following ZIP code only:

Ware	01082

Middlesex County, the following ZIP codes only:

Acton	01720	Holliston	01746
Ashby	01431	Hopkinton	01748
Ashland	01721	Hudson	01749
Ayer	01432	Littleton	01460
Ayer	01434	Lowell	01850
Bedford	01730	Lowell	01851
Billerica	01821	Lowell	01852
Billerica	01822	Lowell	01853
Boxborough	01719	Lowell	01854
Carlisle	01741	Marlborough	01752
Chelmsford	01824	Maynard	01754
Concord	01742	Natick	01760
Dracut	01826	North Billerica	01862
Dunstable	01827	North Chelmsford	01863
Framingham	01701	Nutting Lake	01865
Framingham	01702	Pepperell	01463
Framingham	01703	Pinehurst	01866
Framingham	01704	Sherborn	01770
Framingham	01705	Shirley	01464
Groton	01450	Shirley Center	01464
Groton	01470	Stow	01775
Groton	01471	Sudbury	01776
Hanscomb AFB	01731	Tewksbury	01876
Townsend	01469	West Groton	01472
Tyngsborough	01879	West Townsend	01474
Village of Nagog Woods	01718	Westford	01886
Wayland	01778	Woodville	01784

Norfolk County, the following ZIP codes only:

Bellingham	02019	Norfolk	02056
Franklin	02038	Sheldonville	02070
Medway	02053	Wrentham	02093
Millis	02054		

2 How You Get Care and Prescription Drugs

Providers you can use to get services covered by our Plan.

While you are a member of our Plan, you must use our Plan providers to get your covered services except in limited circumstances such as an emergency**.**

- **What are "plan providers"?** "Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services.

  We call them "plan providers" when they participate in our Plan. When we say that plan providers "participate in our Plan," this means that we have arranged with them to coordinate or provide covered services to members in our Plan.

What are covered services?

Covered services" is the general term we use in this booklet to mean all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 3.

Rules about using non-plan providers to get your covered services.

We list the providers that participate with our Plan in our provider directory. These providers are called network providers. Except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis, you must obtain covered services from network providers for the services to be covered. If you get non-emergency care from non-network providers without prior authorization, you must pay the entire cost yourself.

Choosing Your Primary Care Physician (PCP)

What is a "PCP"?

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP is a physician, physician assistant or nurse practitioner who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. For example, in order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). Example (modify as appropriate): Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- your x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions, and
- follow-up care.

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 6 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose a PCP?

You may choose a PCP by looking in the Provider Directory or by calling Customer Service for assistance. You may change your PCP at any time. If there is a particular specialist or hospital that you want to use, check first to be sure that your PCP makes referrals to that specialist or uses that hospital. Once you have chosen a PCP, you must notify Customer Service of your choice. We will send you a letter confirming the change. You may change your PCP at any time.

How do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get on your own, without contacting your PCP first except as we explain below and in Section 3.

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will also need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 6 tells how we will protect the privacy of your medical records and personal health information.

How do you get care from doctors, specialists and hospitals?

When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists include but are not limited to such doctors as:

- oncologists (who care for patients with cancer)
- cardiologists (who care for patients with heart conditions),
- orthopedists (who care for patients with certain bone, joint, or muscle conditions).

For some types of referrals, your PCP may need to get approval in advance from our Plan (this is called getting "prior authorization").

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.**

If the specialist feels you need additional specialty services, the specialist will ask for authorization directly from Fallon Community Health Plan.

If there are specific specialists you want to use find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a Plan specialist that your current PCP can't refer you to. Later in this section, under "How can you switch to another PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, you must first find out whether the doctors you will be seeing uses these hospitals.

How can you switch to another PCP?

You may change your PCP for any reason, at any time. To change your PCP, call Customer Service.

When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your member record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

What if your doctor or other provider leaves your plan?

Sometimes a PCP, specialist, clinic, hospital or other plan provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan. If your PCP leaves our Plan, we will let you know and help you choose another PCP so that you can keep getting covered services.

What services can you get on your own, without getting a referral (approval in advance) from your Primary Care Physician (PCP)?

You may get the following services on your own, without a referral (approval in advance) from your PCP. You still have to pay your share of the cost, as appropriate, for these services.

- Routine women's health care, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from a plan provider.
- Flu shots, Hepatitis B and pneumonia vaccinations (as long as you get them from a plan provider).
- Routine dental care provided by a plan dentist.
- Mental health and substance abuse outpatient office visits with a plan provider. This does not include partial hospitalization services.
- Emergency services, whether you get these services from plan providers or non-plan providers
- Urgently needed care that you get from non-plan providers when you are temporarily outside the Plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the Plan providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get when you are temporarily outside the Plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.

If you need care when you are outside the service area, your coverage is very limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that Fallon Community Health Plan has approved in advance. If you have questions about what medical care is covered when you travel, please call Customer Service at the telephone number on the cover of this booklet.

Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when you reasonably believe that your health is in serious danger – when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. **You don't need to get approval or a referral first from your PCP or other plan provider.**
- Make sure that your PCP knows about your emergency, because your PCP will need to be involved in following up on your emergency care. You or someone else should call to tell your PCP about your emergency care as soon as possible, preferably within 48 hours.

We will help manage and follow up on your emergency care.

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the world. See Section 2 for filling prescriptions when you cannot access a network pharmacy
- **Ambulance** services are covered in situations where other means of transportation anywhere in the United States would endanger your health.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above). However, please note that:

- If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered additional care **only if you get it from a plan provider.**
- If you get any extra care from a *non-plan provider* after the doctor says it wasn't a medical emergency, the Plan will usually *not* cover the extra care. We will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is urgently needed care? (This is different from a medical emergency)

Urgently needed care refers to a non-emergency situation where you are inside the United States, you are temporarily absent from the Plan's authorized service area, you need medical attention right away for an unforeseen illness, injury, or condition**,** and it isn't reasonable given the situation for you to obtain medical care through the Plan's participating provider network. **Note**: Under unusual and extraordinary circumstances, care may be considered urgently needed when the member is in the service area, but the provider network of the Plan is temporarily unavailable or inaccessible.

What is the difference between a "medical emergency" and "urgently needed care"?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care?

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider. The plan is obligated to cover all urgently needed care at the cost-sharing levels that apply to care received within the Plan network.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined in other sections of this document.

Hospital care, skilled nursing facility care, and other services

How do you get hospital care?

If you need hospital care, we will cover these services for you. Covered services are listed in the Benefits Chart in Section 3 under the heading "Inpatient Hospital Care"

In most cases, your primary care provider will determine which plan hospital you are admitted to based on his or her admitting privileges. For a listing of Fallon Senior Plan Saver hospitals your primary care provider admits to, look in the Provider Directory or call Customer Service at the number on the cover of this booklet.

What is a "benefit period" for hospital care?

Our Plan uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are admitted to the hospital and are receiving inpatient services in the hospital). A "benefit period" begins on the first day you are admitted as an inpatient at a Medicare-covered inpatient hospital (for rehabilitation services) or a skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital (for rehabilitation services) or SNF for 60 days in a row. If you are admitted to the hospital for rehabilitation services (or SNF) after one benefit period has ended, then a new benefit period begins. There is no limit to the number of benefit periods you may have.

Please note that after your hospital day limits are used up, we will still pay for covered physician services and other covered medical services. These services are listed in the Benefits Chart in Section 3 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

As shown in the Benefits Chart in Section 3, you must pay the inpatient hospital copayment for each benefit period.

What happens if you join or leave our Plan during a hospital stay?

If you either join or leave our Plan during an inpatient hospital stay, special rules may apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Customer Service. Customer Service can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a plan member.

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

How do you get Skilled nursing facility care (SNF care)?

If you need skilled nursing facility care, we will cover these services for you. Covered services are listed in the Benefits Chart in Section 3 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

Are Nursing Home stays that provide custodial care covered?

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. We don't cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

What are the benefit period limitations on coverage of skilled nursing facility care?

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A "**benefit period**" begins on the first day you are admitted as an inpatient at a Medicare-covered hospital (for rehabilitation services) or SNF. The benefit period ends when you haven't been an inpatient at any hospital (for rehabilitation services) or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

What are the situations when you may be able to get care in a Skilled Nursing Facility (SNF) that isn't a plan provider?

Generally, you will get your skilled nursing facility care from plan SNFs. However, under certain conditions shown below, you may be able to pay in-network cost-sharing for skilled nursing facility care from a SNF that isn't a plan provider if the SNF accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if our Plan doesn't authorize your care?

Except in cases of medical emergencies, your provider must obtain prior authorization for your SNF stay. We will notify you, your provider and the facility of our decision in writing.

What happens if you join or leave our Plan during a Skilled Nursing facility (SNF) stay?

If you either join or leave our Plan during a SNF stay, please call Customer Service. Customer Service can explain how your services are covered for this stay, and what you owe, if anything, for the periods of your stay when you were and weren't a plan member.

How do you get home health care?

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 3 under the heading "Home health care." If you need home health care services, we will cover these services for you provided the Medicare coverage requirements are met.

When can home health care include services from a home health aide?

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide doesn't have a license or provide therapy. The home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). The services from a home health aide must be part of the home care of plan for your illness or injury, and they aren't covered unless you are also getting a covered skilled service. "Home health services" don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part-time" and "intermittent" home health care services?

If you meet the requirements for getting covered home health services, you may be eligible for "part-time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time" or "intermittent"** means your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

What is hospice care?

"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

How do you get hospice care if you are terminally ill?

As a member of our Plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Customer Service to get a list of the Medicare-certified hospice providers in your area or you may call the Regional Home Health Intermediary at 1-800-MEDICARE (1-800-633-4227).

How is your hospice care paid for?

If you enroll in a Medicare-certified hospice program, the Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a plan provider or a non-plan provider. Even if you choose to enroll in a Medicare-certified

hospice, you will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan.

How to get more information on hospice care

Visit www.medicare.gov on the Web. Under "Search Tools," "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048)

How to get an organ transplant if you need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others aren't). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. The following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

If you are sent outside of your community for a transplant, (where the normal pattern of care is to provide the transplant within the community), the Plan should arrange or pay for appropriate lodging and transportation costs for the member and a companion as well as ensuring post-transplant continuity of care where there is a closer facility that could provide the transplant with which the Plan does not contract.

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care that is unrelated to the clinical trial through our Plan.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in our Plan. For

instance, you will be responsible for Part B coinsurance – generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no coinsurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare coinsurance rules, called "Medicare & You." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web.

You don't need to get a referral (approval in advance) from a plan provider to join a clinical trial, and the clinical trial providers don't need to be plan providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know what services you will get from clinical trial providers and the cost for those services. You may view or download the publication "Medicare and Clinical Trials" At www.medicare.gov on the Web. Under "Search Tools," select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan. You are covered for an unlimited number of days.

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in an SPAP, you may get help paying your premiums and/or co-payments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction section for more information.

If you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you are a member of an employer or retiree group

If you currently have prescription drug coverage through your employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Each year (prior to November 15) your employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (coverage that is at least as good as standard Medicare prescription drug coverage and expects to pay, on average, at least as much as the Medicare standard prescription drug plan expects to pay) and the options available to you. You should keep the disclosure notices that you get each year in your personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer or union.

Using network pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

What is a "network pharmacy"? A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drug. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you aren't required to continue going to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.

- You can obtain an extended supply of medications at all of the retail pharmacies in our network.

What are "covered drugs"? The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call Customer Service to obtain the necessary information to avoid paying the full cost of the prescription. Or, you may pay the full cost of the prescription and ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim".

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy; Directory or call Customer Service to find another network pharmacy in your area.

How do you fill a prescription through our Plan's network mail-order-pharmacy service?

You may use our Plan's mail-order service to fill prescriptions for any drug that can be sent in the mail and is on the formulary list.

When you order prescription drugs through our network mail order pharmacy service, you may order no more than a 90-day supply of the drug.

Generally, it takes us up to 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. Our mail service employs state-of-the-art technology to track and monitor the status of prescription orders throughout the dispensing process. Each step of dispensing requires the identification of all associates involved in handling the order. We generate a daily report which identifies orders that are delayed due to an eligibility issue, medication out of stock, physician call, etc. This report always identifies the oldest order in house, which gains the highest priority for resolution. We will call you to advise you of the reason for the delay and to determine if the medication is urgently needed. If necessary, we will ship the order via overnight delivery or contact a retail pharmacy located near you to authorize the dispensing of a temporary supply.

You aren't required to use our mail-order services to get an extended supply of medications. You can also get an extended supply through all retail network pharmacies. Our retail pharmacies accept the mail-order co-payment or coinsurance for an extended supply of medications.

Filling prescriptions outside the network

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Customer Service to see if there is a network

pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay will help you qualify for catastrophic coverage.

Note: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you went to an in-network pharmacy.

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

Any in-network drug management programs, such as prior authorization and quantity limits, apply to out-of-network purchases.

How do you submit a paper claim?

When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Submit the receipt to us within one year of the date of service. Send this information to:

Fallon Community Health Plan, Inc.
Claims Department
P.O. Box 15121
Worcester, MA 01615-0121

If you submit a paper claim asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 10 to learn more about requesting coverage determinations.

If you get help from and pay co-payments under a drug manufacturer patient assistance program outside our Plan's benefit, you may submit documentation for the amount you paid and have it count towards qualifying you for catastrophic coverage. Please call Customer Service for more information.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay our Plan's medical benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we should cover your prescription drugs, we will cover them as long as the drugs meet all coverage requirements are met (such as the drugs being on our formulary, filled at a network pharmacy, etc.) and they aren't covered by our Plan's medical benefit. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after our Plan's medical benefit stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of–network care, and that the drugs wouldn't otherwise be covered by our Plan's medical benefit. When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage or Prescription Drug Plan. Please see Section 11 of this booklet for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.

Long-term care pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility's long-term-care pharmacy or another network long-term-care pharmacy. Please refer to your *Fallon Senior Plan Provider Network* directory to find out if your long-term-care pharmacy is part of our network. If it isn't, or for more information, please contact Customer Service.

Home infusion pharmacies

Our plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,
- Your prescription drug is not otherwise covered under our Plan's medical benefit,
- Our plan has approved your prescription for home infusion therapy, and
- Your prescription is written by an authorized prescriber.
- You get your home infusion services from a Plan network pharmacy.

Please refer to your *Fallon Senior Plan Provider Network* directory to find a home infusion pharmacy provider in your area. For more information, please contact Customer Service.

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature (including the cost associated with administering the vaccine) and aren't already covered by our Plan's medical benefit. This coverage includes the cost of vaccine administration. (Please see Section 4, "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

3 Covered Benefits

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of our Plan. **"Covered services" means the medical care, services, supplies, and equipment that are covered by** our Plan**.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. Section 7 tells about **services that aren't covered** (these are called "exclusions"). Section 7 also tells about limitations on certain services.

There are some conditions that apply in order to get covered services.

Some general requirements apply to all covered services.

The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 13 for a definition of "medically necessary".)
- With few exceptions, covered services must be provided by plan providers, be approved in advance by plan providers, and some services may need to be authorized by our Plan. The exceptions are care for medical emergency, urgently needed services outside the service area, and renal (kidney) dialysis you get when you are outside the Plan's service area.

In addition, some covered services require "prior authorization" by the Plan in order to be covered.

Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization (approval ahead of time) are marked in italics in the Benefits Chart.

Benefits chart – your covered services

What you must pay when you get these covered services

Inpatient Services

Inpatient hospital care

For more information about inpatient hospital care, see Section 2.

For inpatient hospital care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.

You are covered for an unlimited number of days in an acute care hospital. This includes mental health and substance abuse services, but it does not include rehabilitation services.

You are covered for up to 100 days of care in each benefit period in an inpatient rehabilitation facility or rehabilitation unit of an acute care hospital. If you exceed the 100-day limit in a benefit period, you may use your lifetime reserve days for additional coverage. See Section 13 for an explanation of "benefit period."

Covered services include, but aren't limited to, the following:

- Semiprivate room (or a private room if medically necessary).
- Meals including special diets.
- Regular nursing services.
- Costs of special care units (such as intensive or coronary care units).
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Physical therapy, occupational therapy, and speech therapy.

There is no copayment for inpatient admissions.

If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the same cost sharing you would pay at a plan hospital.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient hospital care, continued • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. See Section 2 for more information about transplants. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician Services.	
Inpatient mental health care *For inpatient mental health care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Includes mental health care services that require a hospital stay. You are covered for an unlimited number of days of inpatient mental health care in an acute care hospital. You are covered for up to 90 days in each benefit period for inpatient mental health care in a psychiatric hospital. There is a 190-day lifetime limit on mental health care in a psychiatric hospital. You may use your lifetime reserve days for additional coverage once you have used the initial 90 days, if you have not reached your 190-day limit. See Section 13 for an explanation of "benefit period."	There is no copayment for inpatient mental health admissions.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Skilled nursing facility care For more information about skilled nursing facility care, see Section 2. *For skilled nursing facility care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* You are covered for up to 100 days in each benefit period for skilled nursing facility care. No prior hospital stay is required. See Section 13 for an explanation of "benefit period." Covered services include, but aren't limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (This includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	There is no copayment for skilled nursing facility admissions.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient services (when the hospital or SNF days aren't or are no longer covered) For more information about inpatient services, see Section 2. *For inpatient services (when the hospital or SNF days aren't or are no longer covered) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but aren't limited to, the following: • Physician services. • Tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	There is no copayment for Medicare-covered inpatient services (when the hospital or SNF days are not or are no longer covered).

Benefits chart – your covered services	**What you must pay** when you get these covered services
Home health agency care For more information about home health agency care, see Section 2 . *For home health care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but aren't limited to, the following: • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	There is no copayment for Medicare-covered home health care.
Hospice care For more information about hospice services, see Section 2. Covered services include, but aren't limited to, the following: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by Medicare, not your Medicare Advantage plan (see Section 2 for more information about hospice services). $15 PCP or $25 specialist office visit copayment may apply for hospice consultation services.
Outpatient Services	
Physician services, including doctor office visits *For some office visits (other than office visits to your PCP) and outpatient services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. For more information, see Section 2.*	You pay a $15 copayment for each office visit with your PCP for Medicare-covered services. You pay a $25 copayment for each office visit with a specialist for Medicare-covered services.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Physician services, including doctor office visits, continued Covered services include, but aren't limited to, the following: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery • Outpatient hospital services. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor). For information on coverage for routine dental care, see page 47. • Infertility services *(For infertility services to be covered, your PCP or other plan provider must get prior authorization – approval in advance – from the plan.)* - Office visits for the diagnosis and treatment of infertility. - Diagnostic laboratory and X-ray services. - Artificial insemination. - In vitro fertilization and embryo placement. - Gamete intrafallopian transfer. - Zygote intrafallopian transfer. - Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs to the extent that such costs are not covered by the donor's insurer.	There is no copayment for Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Physician services, including doctor office visits, continued • Reconstructive surgery *(For reconstructive surgery to be covered, your PCP or other plan provider must get prior authorization – approval in advance from the plan.)* – Surgery for post-mastectomy patients for reconstruction of the breast on which the mastectomy was performed. – Surgery and reconstruction of the other breast to produce a symmetrical appearance. – Treatment for any physical complications resulting from the mastectomy including lymphedema	
Chiropractic services *For chiropractic visits beyond the fifth visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services, include, but aren't limited, to the following: • Manual manipulation of the spine to correct subluxation.	You pay a $15 copayment for each Medicare-covered office visit for chiropractic services.
Podiatry services *For podiatry services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but aren't limited to, the following: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	You pay a $15 copayment for each Medicare-covered office visit for podiatry services.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient mental health care (including Partial Hospitalization Services) *For partial hospitalization services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but are not limited to, the following: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	You pay a $15 copayment for each Medicare-covered individual or group therapy visit for mental health care. You pay a $25 copayment for each Medicare-covered individual or group therapy visit for mental health care with a psychiatrist. There is no copayment for Medicare-covered partial hospitalization services.
Outpatient substance abuse services	You pay a $15 copayment for each Medicare-covered individual or group visit for substance abuse services.
Outpatient surgery *For outpatient surgery to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	There is no copayment for Medicare-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility. You pay a $15 PCP or $25 specialist copayment for each Medicare-covered office visit for outpatient surgery.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Ambulance services *For non-emergency ambulance services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	There is no copayment for Medicare-covered ambulance transport (one-way).
Emergency care For more information, see Section 2. Emergency care is covered worldwide.	You pay a $50 copayment for each emergency room visit or observation room services. You do not pay the emergency room/observation room copayment if you are admitted to the hospital within 72 hours for the same condition. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.
Urgently needed care For more information, see Section 2.	You pay a $15 copayment for each urgent care visit.
Outpatient rehabilitation services *For physical, occupational and speech and language therapy visits beyond the sixth visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but aren't limited to, the following: physical therapy, occupational therapy, and speech and language therapy	You pay a $15 copayment for each Medicare-covered physical, occupational or speech and language therapy visit. There is no copayment for Medicare-covered cardiac rehabilitation therapy.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Durable medical equipment and related supplies – such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 13.) *For durable medical equipment and related supplies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	There is no copayment for Medicare-covered durable medical equipment and related supplies (with the exception of prescription drugs).
Prosthetic devices and related supplies – (other than dental) that replaces a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" on page 49 for more detail. *For prosthetic devices and related supplies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	There is no copayment for Medicare-covered prosthetic devices and related supplies.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). *For diabetes self-monitoring supplies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but aren't limited to, the following: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. Self-management training is covered under certain conditions. As needed for persons at risk of diabetes: Fasting plasma glucose tests. Note: Syringes and insulin (unless used with an insulin pump) are covered under the Fallon Senior Plan Premier outpatient prescription drug benefit.	There is no copayment for diabetes self-monitoring training and supplies. $15 PCP or $25 specialist office visit copayment applies.
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	You pay a $15 copayment for each Medicare-covered visit for medical nutrition therapy

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies *For CT scans, PET scans, MRIs and nuclear studies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but are not limited to, the following: • X-rays. • Radiation therapy. – CT scans – PET scans – MRIs – Nuclear studies • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood - Coverage of blood, its storage and its administration begins with the first pint of blood that you need.	There is no copayment for the following Medicare-covered services: - clinical/diagnostic lab services - radiation therapy $15 PCP or $25 specialist office visit copayment applies.
Preventive Care and Screening Tests	
Bone-mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no copayment for Medicare-covered procedures to measure bone mass.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	There is no copayment for colorectal screening procedures. $15 PCP or $25 specialist office visit copayment applies.
Immunizations *For immunizations (other than the pneumonia vaccine, flu shots and Hepatitis B vaccines) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include, but aren't limited to, the following: • Pneumonia vaccine. As explained in Section 2, you may get this service on your own, without a referral from your PCP, as long as you get the service from a Plan provider. • Flu shots, once a year in the fall or winter. As explained in Section 2, you may get this service on your own, without a referral from your PCP, as long as you get the service from a Plan provider. • If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine. As explained in Section 2, you may get this service on your own, without a referral from your PCP, as long as you get the service from a Plan provider. • Other vaccines if you are at risk. We also cover some vaccines under our outpatient prescription drug benefit**.**	There is no copayment for Medicare-covered immunizations. $15 PCP or $25 specialist office visit copayment applies.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Mammography screening (As explained in Section 2 , you may get this service on your own, without a referral from your PCP, as long as you get the service from a Plan provider.) Covered services include, but aren't limited to, the following: • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	There is no copayment for Medicare-covered screening mammography.
Pap tests, pelvic exams, and clinical breast exam (As explained in Section 2, you may get these routine women's health services on your own, without a referral from your PCP, as long as you get the services from a Plan provider.) Covered services include, but aren't limited to, the following: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 12 months. • If you are at high risk of cancer, Pap tests, pelvic exams and clinical breast exams are covered more frequently when ordered by a plan provider.	There is no copayment for Pap smears, pelvic exams and clinical breast exams. $15 PCP or $25 specialist office visit copayment applies.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: Covered services include, but aren't limited to, the following: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no copayment for digital rectal exams or PSA tests. $15 PCP or $25 specialist office visit copayment applies.
Cardiovascular disease testing Blood tests as needed for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).	There is no copayment for Medicare-covered cardiovascular screening blood tests. $15 PCP or $25 specialist office visit copayment applies.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Physical exams	
Includes routine physical exams for the prevention and detection of disease. Services may include measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests. Note: See "Outpatient diagnostic tests and therapeutic services and supplies" for coverage of labs and X-rays.	You pay a $15 copayment for each routine physical exam.
Other Services	
Dialysis (Kidney)	
For home dialysis equipment to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. Covered services include, but aren't limited to, the following: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply).	There is no copayment for Medicare-covered inpatient or outpatient dialysis. There is no copayment for Medicare-covered training and support services. There is no copayment for Medicare-covered equipment and supplies used for home dialysis (with the exception of prescription drugs).

Benefits chart – your covered services	**What you must pay** when you get these covered services
Prescription Drugs	
That are covered under the Original Medicare Plan (these drugs are covered for everyone with Medicare) "Drugs" includes substances that are naturally present in the body, such as blood-clotting factors. Covered drugs include, but aren't limited to, the following: • Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	There is no copayment for drugs that are administered by a health care professional. $15 PCP or $25 specialist office visit copayment applies. **For prescription drugs that are covered under Original Medicare you pay:** *Retail pharmacy:* Tier 1: $5 copayment for up to a 30-day supply; $10 copayment for up to a 60-day supply; $15 for up to a 90-day supply Tier 2: $25 copayment for up to a 30-day supply; $50 copayment for up to a 60-day supply; $75 for up to a 90-day supply Tier 3: $45 copayment for up to a 30-day supply; $90 copayment for up to a 60-day supply; $135 for up to a 90-day supply *Mail-order pharmacy:* Tier 1: $10 copayment for up to a 90-day supply Tier 2: $50 copayment for up to a 90-day supply Tier 3: $90 copayment for up to a 90-day supply There is no benefit limit on drugs covered under Original Medicare

Benefits chart – your covered services	**What you must pay** when you get these covered services
Prescription Drugs, continued That are covered under the Medicare Prescription Drug Benefit (Part D). Section 4 explains the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 7 also tells about drugs that are not covered by this benefit.	You will pay a copayment for covered prescriptions, until your yearly out-of-pocket Part D prescription drug costs reach $4,050. Section 4 explains your prescription drug benefit in greater detail. *Retail pharmacy:* Tier 1: $5 copayment for up to a 30-day supply; $10 copayment for up to a 60-day supply; $15 for up to a 90-day supply Tier 2: $25 copayment for up to a 30-day supply; $50 copayment for up to a 60-day supply; $75 for up to a 90-day supply Tier 3: $45 copayment for up to a 30-day supply; $90 copayment for up to a 60-day supply; $135 for up to a 90-day supply *Mail-order pharmacy:* Tier 1: $10 copayment for up to a 90-day supply Tier 2: $50 copayment for up to a 90-day supply Tier 3: $90 copayment for up to a 90-day supply
Additional Benefits	
Dental services As explained in Section 2, you can get routine dental services on your own, without a referral from your PCP as long as you get the services from a plan dentist: • Preventive dental care including exam, cleaning, fluoride treatment and X-rays. Limited to once every six months. • Minor restorative dental care such as metal or composite fillings.	You pay a $10 copayment for each preventive dental visit. You pay copayments varying from $19 to $51 for minor restorative dental care. See your "Covered dental services" addendum for more information.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Dental services, continued	
• Out-of-area dental care for minor ailments such as a toothache or loose filling occurring while you are out of the plan service area. Coverage is provided for up to $50 per incident. Go to the closest provider, you do not need a referral from your PCP. • Emergency medical care, such as to relieve pain or stop bleeding as a result of injury to the sound natural teeth or tissue, provided in the office of a physician or dentists as soon as possible after the injury. This does not include restorative or other dental care. Go to the closest provider, you do not need a referral from your PCP.	You pay a $10 copayment for out-of-area dental care You pay a $15 copayment for emergency medical care of the sound natural teeth or tissue.
For oral surgery services (with the exception of the removal or exposure of impacted teeth) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan: • Services by a dentist are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. • Removal or exposure of impacted teeth, including hard and soft tissue impactions, or an evaluation for this procedure. • Surgical treatments of cysts affecting the teeth or gums • Evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed	You pay a $25 copayment for each office visit for oral surgery services.
Hearing services *For diagnostic hearing exams to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* • Diagnostic hearing exams. • Hearing aid allowance of up to $500 in each 36-month period. Note: Routine hearing exams are not covered.	You pay a $15 PCP or $25 specialist copayment for each Medicare-covered diagnostic hearing exam. There is no copayment for hearing aids, once every 36 months. You pay 100% of the cost for any amount over $500 in each 36-month period.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Vision care	
For treatment of diseases or injuries of the eye to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. Covered services include, but aren't limited to, the following: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of a monofocal intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Note: Multifocal or presbyopia-correcting intraocular lenses are not covered. • Routine eye exam, once in each 24-month period. (As explained in Section 2, you can get this service on your own, without a referral from your PCP, as long as you get it from a plan provider.) • Eyewear allowance of up to $150 in each 24-month period for eyeglasses (frames and lenses) at contracted optical providers. Includes fitting, adjustment and repair.	You pay a $15 PCP or $25 specialist copayment for each Medicare-covered office visit for eye care. You pay a $15 PCP or $25 specialist copayment for each routine eye exam. There is no copayment for: - Medicare-covered standard lenses and frames following cataract surgery - Standard lenses and frames

Benefits chart – your covered services	**What you must pay** when you get these covered services
Health and wellness education programs	You pay:
• SilverSneakers® Fitness Program – specialized classes focused on improving strength and flexibility, taught by certified SilverSneakers® fitness instructors at participating health clubs.	- $0 for SilverSneakers® Fitness Program
• Weight Watchers® - members are eligible for one 12-consecutive-week membership, including registration fee, per calendar year.	- $0 for Weight Watchers®
• *Healthy Communities* – published quarterly by Fallon Community Health Plan, our member magazine contains feature articles and information on plan-sponsored events, classes and programs.	- $0 for *Healthy Communities*
• Health education classes. Fees for these programs vary.	- $0 to $15 for health education classes
• Nutritional training, smoking cessation.	- $15 for nutritional training - $0 smoking cessation
• Disease management services provided by Fallon Community Health Plan.	- $0 for disease management services
• *Nurse Connect* – phone and online access to registered nurses and other health care professionals who serve as health coaches which is available 24 hours a day, seven days a week.	- $0 for *Nurse Connect*
For more information on any of these health and wellness education programs, call Customer Service at the number on the cover of this booklet.	

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered for you as a member, we want to help. Please call Customer Service. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 9 for information about making a complaint.

Can your benefits change during the year?

Generally your benefits will not change during the year. The Medicare Program doesn't allow us to decrease your benefits during the calendar year. The only time your benefits

may decrease is at the beginning of the next calendar year. The Medicare Program must approve any decreases we make in your benefits. We will tell you in November if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1.

At any time during the year, the Medicare Program can change its national coverage. Since we cover what the Original Medicare Plan covers, we would have to make any change that the Medicare Program makes. If your benefits increase, the Original Medicare Plan will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay the Original Medicare Plan out-of-pocket amounts for those services. We will let you know in advance if you will have to pay the Original Medicare Plan out-of-pocket costs for an increased benefit.

4 Prescription Drug (Part D) Benefits

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail-order-pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under Utilization management.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions", later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In some cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 2 for more information about filling a prescription at out-of-network pharmacies.

How do you find out what drugs are on the formulary?

You may call Customer Service to find out if your drug is on the formulary or to request a copy of our formulary. The formulary list is also available on the Fallon Community Health Plan website on the Internet at www.fchp.org/seniors/formulary. When you search for a drug using the online formulary, you will need to select "Group," and then select "Fallon Senior Plan Premier – Group 1" from the drop-down menu.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your cost-sharing depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 10 to learn more about how to request an exception.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, add prior authorizations, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to an appropriate drug that we cover or request a formulary exception before the change to the formulary takes effect. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members taking the drug about the change as soon as possible.

What if your drug isn't on the formulary?

If your prescription isn't listed on the formulary, you should first contact Customer Service to be sure it isn't covered.

If Customer Service confirms that we don't cover your drug, you have three options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service or go to our formulary Web site at www.fchp.org.
2. You may ask us to make an exception (which is a type of coverage determination) to cover your drug. See Section 10 to learn more about how to request an exception.
3. You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting an exception (which is a type of coverage determination). This doesn't obligate the Plan to reimburse you if the exception request isn't approved. If the exception isn't approved, you may appeal the Plan's denial. See Section 10 for more information on how to request an appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't in our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage in order to get coverage for the drug. See Section 10 (under "What is an exception") to learn more about how to request an exception. Please contact Customer Service if your drug is not on our formulary, is subject to certain restrictions, such as prior or step therapy or will no longer be on our formulary next year, and you need help switching to an appropriate drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide you with the opportunity to request a formulary exception in advance for the following year.

For each of the drugs that isn't on our formulary or that has coverage restrictions or limits, we will cover a temporary 30-day supply (unless the prescription is written for fewer days) when a new member goes to a network pharmacy and the drug is otherwise a "Part D drug". After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan, when that member is a resident of a long-term-care facility. If a new member, who is a resident of a long-term-care facility and has been enrolled in our Plan for more than 90 days, needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and that are bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that authorized prescribers will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 30 tablets per month for Zestril®.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary on our formulary Web site or by calling Customer Service. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 10 for more information about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

Your enrollment in this Plan doesn't affect Medicare coverage for drugs covered under Medicare Part A or Part B. Depending on the Medicare coverage criteria there may be some variation in the cost-sharing applied to the drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

See your *Medicare & You* handbook for more information about drugs that are covered by Medicare Part A and Part B.

5 Your Costs for This Plan

Paying your monthly plan premium

As a member of our Plan, you pay:

1) Your monthly Medicare Part B premium
2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).

As a member of Fallon Senior Plan Premier, your plan sponsor may pay the plan premium to Fallon Community Health Plan for your coverage

Some plan sponsors pay the plan premium to Fallon Community Health Plan each month on behalf of their members. Fallon Community Health Plan sends the bill for your plan premium to your plan sponsor. The plan sponsor determines the amount (if any) that you pay toward the plan premium each month. Fallon Community Health Plan is not responsible if your plan sponsor fails to pay the plan premium. This is true even if you have paid all or part of the plan premium to your plan sponsor. You can obtain information on the plan premium from your plan sponsor or you can call our Customer Service at the telephone number on the cover of this booklet.

Some plan sponsors require you to pay the monthly plan premium to Fallon Community Health Plan (plan sponsor is not making paying the premium on your behalf). Fallon Community Health Plan sends the bill for your plan premium directly to you, and you must send the payments to Fallon Community Health Plan. If you have any questions about your plan premiums or Fallon Community Health Plan's payment programs, please call our Customer Service at the telephone number on the cover of this booklet. You can also contact your plan sponsor for information on the plan premium.

Paying your share of the cost when you get covered services or drugs

What are "co-payments" and "coinsurance"?

- A **"co-payment"** is a payment you make for your share of the cost of certain covered services or drugs you get. A co-payment is a set amount per service or drug (such as paying $15 for a doctor visit). You pay it when you get the service or drug. The Benefits Chart in Section 3 gives your co-payments for covered services. Co-payments for prescription drugs are listed later in this section.

What is the maximum amount you will pay for Medicare-covered Part A and B services?

There is a limit to how much you have to pay out-of-pocket for your covered health care services each year. Once the total costs for your drugs, including your co-payments, reaches $3,250, then you won't have to continue paying for these expenses for the remainder of the year.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see "Do you qualify for extra help?" later in this section, and the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs."

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below.

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the co-payment. Your co-payment will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs*:

Drug Tier	Retail Co-payment (30 day Supply)	Retail Co-payment (90 day Supply)	Mail-Order Co-payment (30-day supply)	Mail-Order Co-payment (90-day supply)	Out of Network Co-payment
Tier 1	$5	$15	$5	$10	Same as in network cost
Tier 2	$25	$75	$25	$50	Same as in network cost
Tier 3	$45	$135	$45	$90	Same as in network cost

*** Amounts in this chart may vary according to your individual out-of-network cost-sharing responsibility.**

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,050 out-of-pocket for the year. When the total amount you have paid toward your co-payments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,050, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of $2.25 for generics or drugs that are treated like generics and $5.60 for all other drugs or 5% coinsurance. We will pay the rest.

Note: We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your initial coverage limit or total out of pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).

Vaccines (including administration)

Our Plan's prescription drug benefit covers a number of vaccines (including vaccine administration). The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, and then you will be reimbursed. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

If you obtain the vaccine at:	And get it administered by:	You pay (and are reimbursed)
The Pharmacy	**The Pharmacy (not possible in all States)**	You pay co-payment
Your Doctor	**Your Doctor**	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less co-payment. Or, if your doctor agrees to submit your claim on your behalf, you pay co-payment

If you obtain the vaccine at:	And get it administered by:	You pay (and are reimbursed)
The Pharmacy	**Your Doctor**	You pay co-payment at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less co-payment

We can help you understand the costs associated with vaccines (including administration) available under our Plan, especially before you go to your doctor. For more information, please contact Customer Service.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy, and otherwise meets our coverage requirements:

- Your coinsurance or co-payments;

When you have spent a total of $4,050 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't **count** toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs will not count toward your out-of-pocket costs:

Prescription drugs purchased outside the United States and its territories;
Prescription drugs not covered by the Plan;
Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage.
Prescription drugs covered by Part A or Part B.
Non-Part D drugs are covered under our additional coverage. See Section 4 for more information on the excluded non-Part D drugs we may cover as part of our additional coverage.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't **count** toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

What extra help is available?

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's monthly premium and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income

benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.

2 **You apply and qualify.** You may qualify if your yearly income in 2007 is less than $15,315 (single with no dependents) or $20,535 (married and living with your spouse with no dependents), and your resources are less than $11, 710 (single) or $23, 410 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium and prescription co-payments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs".

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to provide evidence of your proper co-payment level. Contact Customer Service to notify us that you have a concern about your copayment amount. We will document your call and ask you to send evidence of your proper co-payment level (e.g., a letter from the state) as soon as possible, but preferably within 30 days, to the Customer Service address in Section 1.

Please be assured that if you overpay your co-payment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn't collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

What is your cost for services that aren't covered under our Plan?

You are responsible to pay the full cost of care and services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination or a coverage determination made for the service. You may call Customer Service and tell us you would like a decision on whether the service will be covered.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service, unless your plan offers, as a covered supplemental benefit, coverage beyond the original Medicare limits. For example, you may have to pay the full cost of any skilled nursing facility care you get after our Plan's payments reach the benefit limit. Paying for costs once a benefit limit has been reached will not count toward your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

Using all of your insurance coverage

If you have additional health insurance coverage prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the health drug benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell our Plan if you have additional health insurance or drug coverage

Important Information about Medicare Prescription Drug Coverage

We will send you our Coordination of Benefits Annual Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional drug coverage, you are required to provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional prescription drug coverage, please call Customer Service to update your member record.

You must tell us if you have any other health insurance coverage or prescription drug coverage besides our Plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

- Coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse.

- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for dental insurance.
- Coverage you have for prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Section 2, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the service area for our Plan, care that has been approved in advance by our Plan, and services that we denied but that were overturned in an appeal. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at Fallon Community Health Plan, Claims Department, P.O. Box 15121, Worcester, MA 01615-0121. It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services we will pay you for our share of the cost. If you get a bill for the services, you may send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You won't have to pay a non-plan provider any more than what they would have gotten from you if you had been covered under the Original Medicare Plan.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and you go without creditable prescription drug coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Customer Service to find out more about the reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had creditable prescription drug coverage (as good as Medicare's)
- The period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You prove that you were not informed that your prescription drug coverage was not creditable
- You lived in an area affected by Hurricane Katrina AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you join a Medicare prescription drug plan by December 31, 2007, AND you stay in a Medicare prescription drug plan

Your late enrollment penalty may be reduced or eliminated if:

- You receive extra help in 2008 or after

6 Your rights and responsibilities as a member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this Section, we explain your Medicare rights and protections as a member of our Plan and, we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "find a Medicare Publication." If you have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our Plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Customer Service at the phone number in Section 1. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. *For example, you have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies).* You also have the right to ask us to

make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service at the phone number in Section 1 of this booklet. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Your right to see plan providers, get covered services, and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of our Plan. You have the right to choose a plan provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. You have the right to timely access to your prescriptions at any network pharmacy.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. Note: This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations are discussed in Section 9. Coverage determinations are discussed in Section 10.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to have information about advance directives, and you have the right to have an advance directive if you so desire. An advance directive is a legal document that allows you to create instructions for your health care in the event that you are later unable to express your wishes because of serous illness or injury." There are different types of advance directives. They are "health care proxy," "living will," and "durable power of attorney for health care."

Health Care Proxy

If you are at least 18 years old and of sound mind (can make decisions on your own), you can use a health care proxy to choose someone that you trust to make health care decisions for you (your "agent"). This person then will make health care decisions according to your instructions if, for any reason, you become unable to make or communicate those decisions yourself. A health care proxy is legally binding in Massachusetts.

Living Will

This is a document in which a person specifies the kind of life-saving and life-sustaining care and treatment he or she does or does not wish to receive in the event the person becomes both incapacitated and terminally ill. Many states have their own titles for a living will document such as "Directive to Physicians," "Declaration Concerning Health Care," etc. Massachusetts law considers the document good evidence of patient wishes; however, it is not legally binding in Massachusetts.

Durable Power of Attorney for Health Care

This is a legal document through which a person appoints someone else, an "attorney-in-fact," to act on the person's behalf in making medical treatment decisions in case of future incapacitation.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, from some office supply stores, or by calling Customer Service at the number on the cover of this booklet. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as the SHINE Program. Section 1 of this booklet tells how to contact the SHINE Program. Regardless of where you get this form, keep in mind that it is a legal document. You may consider having a lawyer help you prepare it; however, this is not necessary in the state of Massachusetts. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you have not signed an advance directive form, but decide when you go to the hospital that you want one, the hospital has forms available for you to sign at that time.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.
If you believe that FCHP does not provide adequate information on advance directives, you may file a complaint with the Massachusetts Division of Medical Assistance.

If you *have* signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

Against a hospital:
Department of Public Health
Division of Health Care Quality
Complaint Unit
99 Chauncy St.
Boston, MA 02111
1-800-462-5540

Against an individual doctor:
Board of Registration in Medicine
Consumer Protection Manager
560 Harrison Avenue, Suite G-4
Boston, MA 02118
1-800-377-0550

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. A complaint can be called a grievance, an organization determination, or a coverage determination depending on the situation. See Section 8 for more information about complaints.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

Your right to get information about our Plan, plan providers, drugs, health care coverage, and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay.

If you need more information, please call Customer Service at the number in Section 1 of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by our Plan. *We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision.* See Section 9 and Section 10 for more information about filing an appeal.

You also have the right to get information from us about our Plan. This includes information about our financial condition, about our Plan health care providers and their qualifications, about information on our network pharmacies, and how our Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Customer Service at the phone number in Section 1 of this booklet. You have the right under

law to have a written/binding advance coverage determination made for the service, even if you obtain this service from a provider not affiliated with our organization.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the number in Section 1 of this booklet. You can also get free help and information from your SHIP (contact information for your SHIP in Section 1 of this booklet). You can also visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What to do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Customer Service or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP (contact information for your SHIP is in Section 1 of this booklet).

Your responsibilities as a member of our Plan

Your responsibilities include the following:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service if you have any questions.
- Letting us know if you have additional health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan enrollment card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your plan premiums and your co-payments for your covered services. You must pay for services that aren't covered.

- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service at the phone number in Section 1 of this booklet.

Your right to get information about your drug coverage and costs

This EOC tells you what you have to pay for prescription drugs as a member of our Plan. If you need more information, please call our Customer Service numbers in Section 1. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 10 for more information about filing an appeal. You also have the right to receive an explanation from us of any utilization-management requirements, such as step therapy or prior authorization that may apply to your plan. If you have any questions please review your formulary Web site or call Customer Service.

Your right to get information about our Plan and our network pharmacies

You have the right to get information from us about our Plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Customer Service at the phone number shown in Section 1.

What can you do if you think you have been treated unfairly or your rights aren't being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you may call our Customer Service numbers listed in Section 1. You can also get help from your State Health Insurance Assistance Program, or SHIP (contact information for your SHIP is in Section 1 of this booklet).

7 General Exclusions

Introduction

The purpose of this section is to tell you about medical care and services, items and drugs that aren't covered ("excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items and drugs that aren't covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 3 also explains about some restrictions or limitations that apply to certain services).

If you get services, items and drugs that are not covered, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items or drugs that we should have paid or covered (appeals are discussed in Section 9 and Section 10).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart in Section 3, or anywhere else in this booklet, **the following items and services aren't covered except as indicated by our Plan:**

1. Services that aren't covered under the Original Medicare Plan.
2. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
3. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. In 2008 CMS will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to MA plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
4. Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare plan.
5. Private room in a hospital, *unless* medically necessary.
6. Private duty nurses.

7. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.

8. Nursing care on a full-time basis in your home.

9. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

10. Homemaker services.

11. Charges imposed by immediate relatives or members of your household.

12. Meals delivered to your home.

13. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.

14. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.

15. Major restorative dental care (such as orthodontia, crowns, root canals or dentures). Certain dental services received at a hospital may be covered.

16. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine, as outlined in Section 3) and is limited according to Medicare guidelines.

17. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.

18. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

19. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

20. Routine hearing examinations.

21. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.

23. Acupuncture.

24. Naturopath services.

25. Services provided to veterans in **V**eterans **A**ffairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.

26. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Drug exclusions

A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B. Also, while a Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted.[1] If the use is not supported by one of these reference books (known as compendia), then the drug is considered a non-Part D drug and cannot be covered by our Plan

By law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	

We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. This includes benzodiazepines and barbiturates, as well as drugs when used for the treatment of sexual or erectile dysfunction. The amount you pay when you fill a

[1] These reference books are: (1) American Hospital Formulary Service Drug Information, (2) the DRUGDEX Information System, and (3) USPDI (or its successor).

prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary to find out which drugs we are offering additional coverage for or call Customer Service if you have any questions.

8 How to file a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an organization determination, a coverage determination, or an appeal, as described in Section 9 and Section 10 of this manual because grievances do not involve problems related to approving or paying for care or Part D benefits, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not give you the services and/or drugs you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 9 and/or 10.

What types of problems might lead to your filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from Customer Service.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems with how long you have to wait in a network pharmacy.
- Problems getting appointments when you need them, or waiting too long for them.
- Waiting too long for prescriptions to be filled.
- Rude behavior by doctors, nurses, receptionists, network pharmacists or other staff.
- Cleanliness or condition of doctor's offices, clinics, network pharmacies, or hospitals.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in more detail in section 9 or section 10.
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required time frame (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss fast grievances in more detail in Section 9 and/or Section 10.

Filing a grievance with our Plan

If you have a complaint, please call the phone number for **Part C Grievances** and/or **Part D Grievances** in Section 1 of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the grievance procedure.** To use the grievance procedure, you may file your grievance orally or in writing to Fallon Community Health Plan Customer Service, 10 Chestnut St., Worcester, MA 01608. You may call Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), 8 a.m. to 8 p.m., seven days a week, and ask them to file a grievance for you. Your grievance must be filed within 60 days of the event. You may request an expedited grievance if we have refused to grant an expedited organization determination or reconsideration or if we have extended the time frame to make an organization determination or reconsideration. If you meet these conditions, your expedited grievance will be handled within 24 hours. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to Masspro

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review organization called Masspro, or both. If you file with Masspro, we must help Masspro resolve the complaint. See Section 1 for more information about Masspro.

How to file a quality of care complaint with Masspro

You must write to Masspro to file a quality of care complaint. You may file your complaint with Masspro at any time. See Section 1 for more information about how to file a quality of care complaint with Masspro.

9 What to Do if you have Complaints about Your Part C Medical Services and Benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. **Please see Section 10 for complaints about prescription drugs (Part D)**. Federal law guarantees your right to make complaints if you have concerns or problems with your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

Please refer to Original Medicare of your 2008 Medicare & You Handbook for additional guidance on your appeal rights under Original Medicare. If you do not have a Medicare & You Handbook, please call 1-800 Medicare to get a copy.

How to make complaints in different situations

This section tells you how to make a complaint about services or payment disputes in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you want to make a complaint about any situation not listed above, you may file a **grievance**. **For more information about grievances, see Section 8.**

PART 1. Complaints about what benefit or service the Plan will approve or what the Plan will pay for

What are "complaints about your services or payment for your care?"

- If you are not getting the care you want, and you believe that this care is covered by the Plan.
- If we will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.

- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the Plan, but we have refused to pay for this care because we say it is not medically necessary or is not a plan benefit.

What is an organization determination?

An organization determination is our **initial decision** about whether we will provide the medical care or service you request, or pay for a service you have received.

If our initial decision is to deny your request, you may **appeal** the decision by going to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

When we make an "organization determination," we are giving our interpretation of how the benefits and services that are covered for members of the Plan apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by the Plan, including any limits on these services. This booklet also lists services that are "not covered" by the Plan.

Who may ask for an "organization determination" about your medical care or payment?

Your doctor or other medical provider may ask us whether we will approve the treatment. You may also ask us for an initial decision, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to be your representative. This statement must be sent to us at the address listed under **Part C Organization Determinations** in **Section 1** of this booklet. Please call us at the phone number shown under **Part C Organization Determinations** for more information. You also have the right to have a lawyer act for you. You can get your own lawyer, or find a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to call the SHINE Program at 1-800-882-2003 (TDD/TTY: 1-800-872-0166), Monday through Friday, 9 a.m. to 8 p.m.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will pay for or approve medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is also called an "expedited organization determination." You may ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the address listed under **Part C Organization Determinations** in **Section 1** of this booklet

Asking for a fast decision

You, any doctor, or your representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us. Or you may send or fax us a written request to the fax number or address listed under **Part C Organization Determinations** in Section 1 of this booklet. Requests made outside of regular weekday business hours must be delivered by phone. Be sure to ask for a "fast" or "72-hour" review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that you don't need a fast decision, we will send you a letter informing you that if you get a doctor's support for a "fast" decision, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 8.

What happens next when you request an initial decision?

1. For a decision about payment for care you already received.

We have 30 days to make a decision after we receive your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the time frame for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called a "reconsideration.")

2. For a standard decision about medical care.

We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance". If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. *For a fast decision about medical care.*

If you receive a "fast" decision, we will give you our decision about your requested medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any extra days, you can file a fast grievance.

We will call you as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of calling you. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request and you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If we deny any part of your request for a service or payment of a service, you may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration."

Please call us if you need help in filing your appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about a service you asked for, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" appeal are the same as those described for a "standard" or "fast" initial decision.

Getting information to support your appeal

If we need your help in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get your doctor's records or your doctor's opinion to support your request. You may need to give your doctor a written request to get information.

You can give us additional information to support your appeal by calling, faxing, or writing to the numbers or address listed under **Part C Appeals** in **Section 1** of this booklet. You can also deliver additional information in person to the address listed under **Part C Appeals** in **Section 1** of this booklet. You also have the right to ask us for a copy of the information we have regarding your appeal. You may call or write us at the numbers or address listed under **Part C Appeals** in **Section 1** of this booklet. We are allowed to charge a fee for copying and sending this information to you.

How do you file your appeal of the organization determination?

The rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an 'organization

determination' about medical care or payment?" However, providers who do not have a contract with the Plan must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file your appeal within 60 days after we notify you of our decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you may call or write us at the phone number or address listed under **Part C Appeals** in Section 1 of this booklet.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" decision.

How soon must we decide on your appeal?

1. For a decision about payment for care you already received.

After we receive your appeal, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

2. For a standard decision about medical care.

After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. For a fast decision about medical care.

After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens next if we rule completely in your favor?

1. For a decision about payment for care you already received.

   We must pay within 60 days of the day we received your appeal.

2. For a standard decision about medical care.

   We must authorize or provide your requested care within 30 days of receiving your appeal. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

3. For a fast decision about medical care.

   We must authorize or provide your requested care within 72 hours of receiving your appeal – or sooner, if your health requires it. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

Appeal Level 2: If on your Level 1 appeal, we do not rule completely in your favor, your appeal will automatically be reviewed by an independent review entity

If we do not rule completely in your favor, your appeal is automatically sent to Appeal Level 2 where an independent review entity that has a contract with CMS (**C**enters for **M**edicare & Medicaid **S**ervices), the government agency that runs the Medicare program, and is not part of the Plan, will review your appeal. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal depends on the type of appeal:

1. For a decision about payment for care you already received.

   We must forward your appeal to the independent review entity within 60 days of the date we received your Level 1 appeal.

2. For a standard decision about medical care.

   We must forward your appeal to the independent review entity as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. For a fast decision about medical care.

   We must forward your appeal to the independent review entity within 24 hours of our decision.

We will send the independent review entity a copy of your case file. You also have the right to get a copy of your case file from us by calling or writing us at the phone number or address listed under **Part C Appeals** in Section 1 of this booklet. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review entity decide?

1. For an appeal about payment for care, the independent review entity has 60 days to make a decision.
2. For a standard appeal about medical care, the independent review entity has 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.
3. For a fast appeal about medical care, the independent review entity has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the independent review entity decides completely in your favor:

The independent review entity will tell you in writing about its decision.

1. For an appeal about payment for care.

   We must pay within 30 days after receiving the decision.

2. For a standard appeal about medical care.

   We must authorize the care you requested within 72 hours after receiving the decision, or provide the care no later than 14 days after receiving the decision.

   We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, e.g., because of your medical condition or you are outside of the service area, we must authorize the services within 72 hours from the date we receive notice that the independent review entity reversed the determination.

3. For a fast appeal about medical care.

   We must authorize or provide the care you requested within 72 hours after receiving the decision.

Appeal Level 3: If the entity that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

You must ask for a review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you received from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement included in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

How soon will the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and decide as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 days of the date we receive notice of the decision. However, we have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

Appeal Level 4: If the Judge does not rule completely in your favor, you may ask for a review by the Medicare Appeals Council

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may ask for a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will send a notice informing you of any action it has taken on your request. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will decide as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical care you requested within 60 days of the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care you asked for meets the minimum requirement.

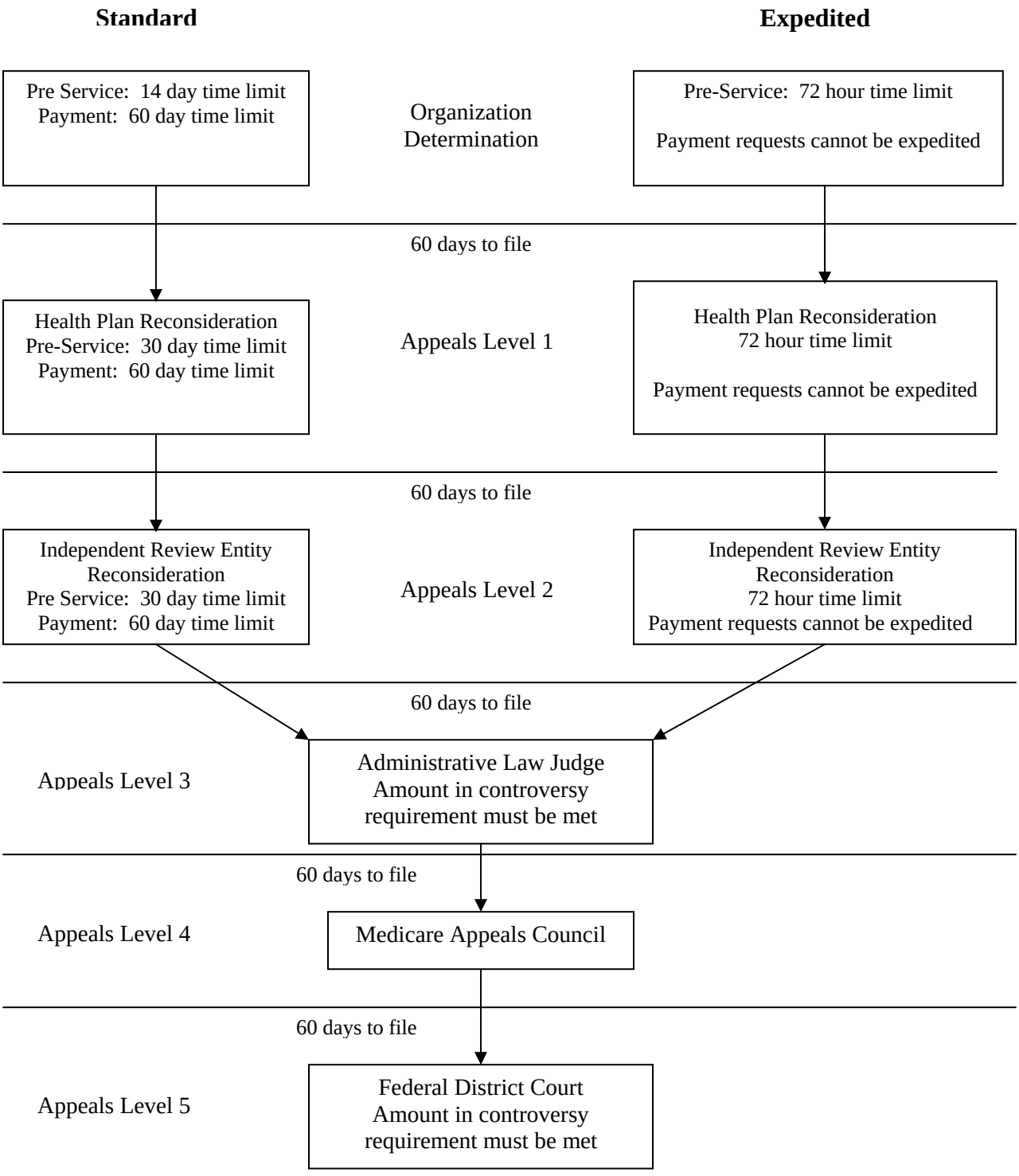
Appeal Level 5: If the Medicare Appeal Council does not rule completely in your favor, you may ask for a review by a Federal Court

You may file an appeal in Federal court if you receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to you or the MAC decided not to review your case. The letter you get from the MAC will tell you how to ask for this review. The Federal Court Judge will first decide whether to review your case. Your appeal will not be reviewed by a Federal Court if the dollar value of the care you asked for does not meet the minimum requirement included in the MAC's decision.

How soon will the Judge make a decision?

The Federal judiciary controls the timing of any decision. The Judge’s decision is final

Complaint process for what benefit or service the Plan will approve or what the Plan will pay for



PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient, someone at the hospital must give you a notice called the Important Message from Medicare (call our Plan Customer Service phone number listed in **Section 1** or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable co-payments).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable co-payments).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called Masspro. The doctors and other health experts in Masspro review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting QIO review of your hospital discharge

You must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO.**
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay for as long as it is medically necessary (except for any applicable co-payments).

What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care as long as it is medically necessary (except for any applicable co-payments).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the Administrative Law Judge (ALJ) appeal. If the ALJ upholds the decision, you may also be

able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers (Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care as long as it is medically necessary (except for any applicable co-payments).

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary (except for any applicable co-payments).
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments).

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services is ending too soon

When you are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call the Plan Customer Service phone number in **Section 1** or 1-800 Medicare (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Getting QIO review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the **Q**uality **I**mprovement **O**rganization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for QIO review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during the QIO's review?

The QIO will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end (call the Plan Customer Service phone number in Section 1 or 1-800-Medicare to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA or CORF services for as long as they are medically necessary (except for any applicable co-payments).

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIOs first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council or a Federal Court. If either the Medicare Appeal Council or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments).

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services for as long as they are medically necessary.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) appeal. If the IRE upholds our decision, you may also

be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are medically necessary (except for any applicable co-payments).

10 What to Do if You have Complaints about Your Part D Prescription Drug Benefits

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call **Customer Service** at the number in **Section 1** of this booklet.

Please note that this section addresses complaints about your Part D prescription drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in Section 9.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For more information about grievances, see Section 8.

A coverage determination is the first decision we make about covering the drug you are requesting. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you may contact us if you want to request a coverage determination. For more information about coverage determinations and exceptions, see the section "How to request a coverage determination" below.

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You cannot request an appeal if we have not issued a coverage determination**.** If we issue an unfavorable coverage determination, you may file an appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section "The appeal process" below.

How to request a coverage determination

What is the purpose of this section?

This part of Section 10 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a coverage determination?

The coverage determination we make us is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact us and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you may "appeal" the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage-determination requests:

- You ask us to pay for a prescription drug you have received. This is a request for a coverage determination about payment. You may call us at the phone number shown under **Part D Coverage Determinations** in **Section 1** of this booklet to ask for this type of decision.

- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**

- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, or quantity limits. Requesting an exception to a utilization management tool is a type of formulary exception. You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**

- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**

- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling Prescriptions Outside of Network" in Section 2 for a description of these circumstances. You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

What is an exception?

An exception is a type of coverage determination. You may ask us to make an exception to our coverage rules in a number of situations.

- You may ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.

- You may ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more. **See Section 4 ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs**."

- You may ask us to provide a higher level of coverage for your drug. If your drug is contained in our Tier 3, you may ask us to cover it at the cost-sharing amount that applies to drugs in the Tier 2 instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative drugs included on the Plan formulary or the drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.

Who may ask for a coverage determination?

You, your prescribing physician, or someone you name may ask us for a coverage determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. This statement must be sent to us at the address listed under **Part D Coverage Determinations** in Section 1 of this booklet. To learn how to name your appointed representative, you may call Customer Service at the number in Section 1 of this booklet.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?

A decision about whether we will give you or pay for a Part D prescription drug can be a "standard" coverage determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is also called an "expedited coverage determination."

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are asking us to pay you back for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** in Section 1 of this booklet. Requests made outside of regular weekday business hours must be delivered by phone.

Asking for a fast decision

You, your doctor, or your appointed representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** in Section 1 of this booklet. Requests made outside of regular weekday business hours must be delivered by phone. Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard time frame.

What happens when you request a coverage determination?

1. For a <u>standard</u> coverage determination about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

   Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage or quantity limits), we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

   If you have not received an answer from us within 72 hours after we receive your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. For a <u>fast</u> coverage determination about a Part D drug that you have not received.

   If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review – sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

   If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens if we decide completely in your favor?

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

   We must give you the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. For a fast decision about a Part D drug that you have not received.

   We must give you the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If a coverage determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1.)

The appeals process

This part of Section 10 explains what you can do if you disagree with our coverage determination.

What kinds of decisions can be appealed?

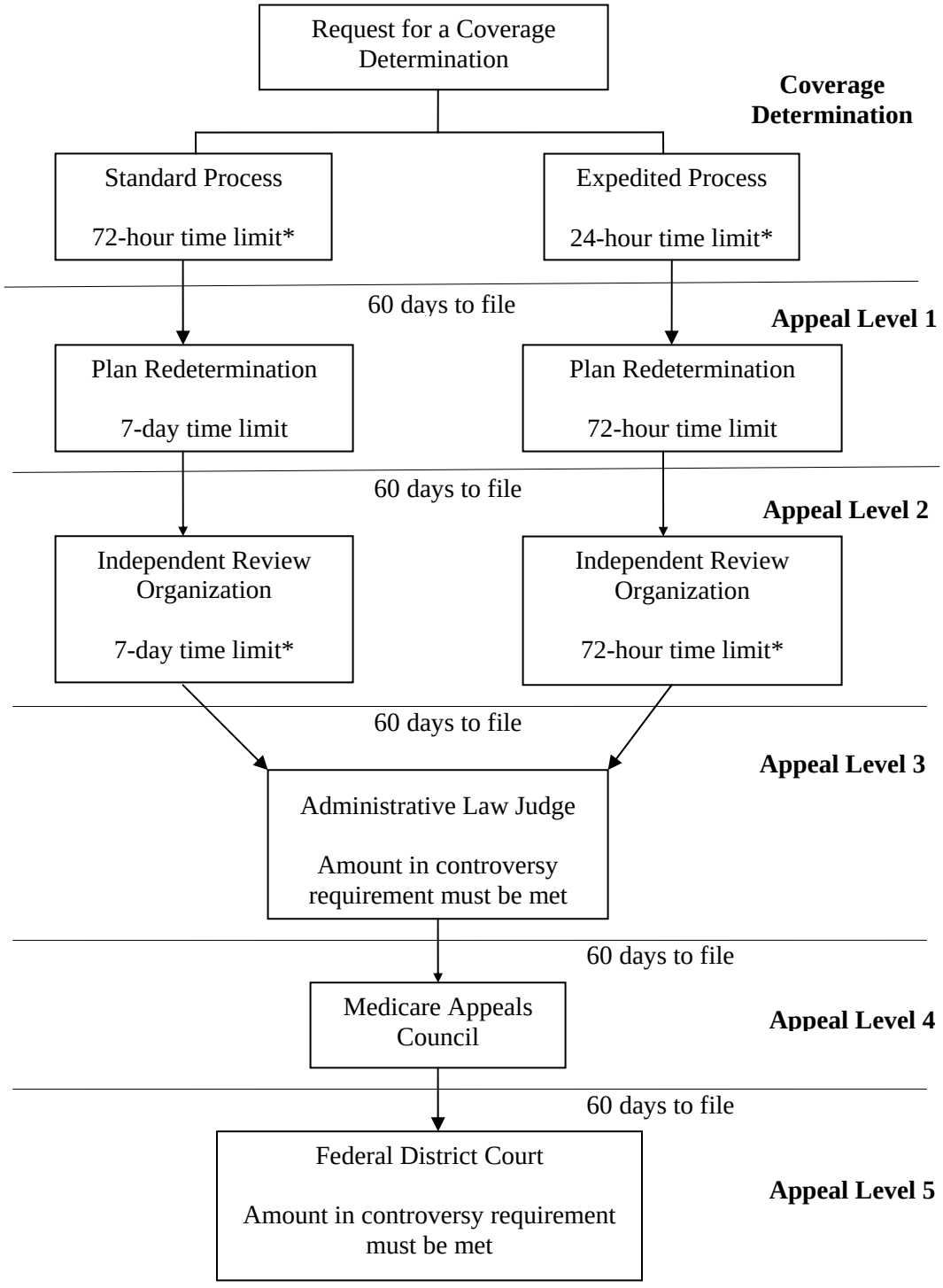
If you are not satisfied with our coverage determination decision, you may ask for an appeal called a "redetermination." You may generally appeal the following decisions:

- We do not cover a Part D drug you think you are entitled to receive,
- We do not pay you back for a Part D drug that you paid for,
- We paid you less for a Part D drug than you think we should have paid you,
- We ask you to pay a higher co-payment amount than you think you are required to pay for a Part D drug, or
- We deny your exception request.

How does the appeals process work?

There are five levels in the appeals process. At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may give you some or all of what you have asked for, or it may not give you anything you asked for. If you are unhappy with the decision, you may be able to appeal it and have someone else review your request.

The following chart summarizes the appeals process. Each appeal level is discussed in greater detail below.



*The adjudication time frames generally begin when the request is received by the Plan sponsor. However, if the request involves an exception to the Plan's formulary, the adjudication time frame begins when the Plan sponsor or independent review organization receives the doctor's supporting statement.

Appeal Level 1: If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called a "request for redetermination."

You may ask us to review our coverage determination, even if only part of our decision is not what you requested. When we receive your request to review the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the coverage determination?

You or your appointed representative may file a **standard appeal** request.

You, your appointed representative, or your doctor may file a **fast appeal** request.

How soon must you file your appeal**?**

You must file the appeal request within 60 calendar days from the date included on the notice of our coverage determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal, you or your appointed representative may send a written appeal request to the address listed under **Part D Appeals** in Section 1 of this booklet.

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part D drug that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in **Section 1** of this booklet. Requests made outside of regular weekday business hours must be delivered by phone. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in Section 1 of this booklet. You may also deliver additional information in person to the address listed under **Part D Appeals** in Section 1 of this booklet. You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** in Section 1 of this booklet. We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

   We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to the second level of appeal, where an independent review organization will review your case.

2. For a fast decision about a Part D drug that you have not received.

   We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens if we decide completely in your favor?

1. For a standard decision to pay you back for a Part D drug you already paid for and received.

   We must send payment to you no later than 30 calendar days after we receive your appeal request.

2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within seven calendar days we receive your appeal request. We will give it to you sooner if your health requires us to.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 72 hours after we receive your appeal request. We will give it to you sooner if your health requires us to.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. We are allowed to charge a fee for copying and sending this information to you.

Who may file your appeal?

You or your appointed representative may file a **standard** or **fast** appeal request.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days after the date you were notified of the decision on your first appeal. The independent review organization may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal, you or your appointed representative can send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us.

2. Asking for a fast appeal

To ask for a fast appeal, you or your appointed representative may send a written appeal request to the independent review organization at the address included in the redetermination notice you receive from us. Remember, if your doctor provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically give you a fast appeal.

How soon must the independent review organization decide?

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug that you have already paid for and received.

   The independent review organization will give you its decision within seven calendar days after it receives your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

2. For a fast decision about a Part D drug that you have not received.

   The independent review organization will give you its decision within 72 hours after they receive your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already paid for and received.

   We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. For a standard decision about a Part D drug you have not received.
   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

If the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge if the dollar value of the Part D drug you asked for meets the minimum requirement provided in the independent review organization's decision. During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

Who may file your appeal?

You or your appointed representative may file an appeal request with an Administrative Law Judge.

How soon must you file your appeal?

The appeal request must be filed within 60 calendar days of the date you were notified of the decision made by the independent review organization (Appeal Level 2). The Administrative Law Judge may give you more time if you have a good reason for missing the deadline.

How to file your appeal

The request must be filed with an Administrative Law Judge in writing. The written request must be sent to the Administrative Law Judge at the address listed in the decision you receive from the independent review organization (Appeal Level 2).

The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes:

- Any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the Plan year,
- Your co-payments,
- All drug expenses after your drug costs exceed the initial coverage limit, and
- Payments for drugs made by other entities on your behalf.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon will the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 4: If an ALJ does not rule in your favor, your case may be reviewed by the Medicare Appeals Council

If the Administrative Law Judge does not rule completely in your favor, you or your appointed representative may ask for a review by the Medicare Appeals Council.

Who may file your appeal?

You or your appointed representative may request an appeal with the Medicare Appeals Council.

How soon must you file your appeal?

The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Administrative Law Judge (Appeal Level 3). The Medicare Appeals Council may give you more time if you have a good reason for missing the deadline.

How to file your appeal

The request must be filed with the Medicare Appeals Council. The decision you receive from the Administrative Law Judge (Appeal Level 3) will tell you how to file this appeal.

How soon will the Council make a decision?

The Medicare Appeals Council will first decide whether to review your case (it does not review every case it receives). If the Medicare Appeals Council reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 5: If the Medicare Appeals council does not rule in your favor, your case may go to a Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the Medicare Appeals Council decided not to review your appeal request.

Who may file your appeal?

You or your appointed representative may request an appeal with a Federal Court.

How soon must you file your appeal?

The appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4).

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the Medicare Appeals Council's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you within 30 calendar days after we receive notice reversing our coverage determination.

2. For a standard decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Part D drug you have not received.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

If the Judge decides against you:

The Judge’s decision is final and you may not take the appeal any further.

11 Ending your Membership

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

In general, there are only certain times during the year when you may voluntarily end your membership in our Plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit **www.medicare.gov** to learn more about your options.

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself.

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through our Plan.

If you must get services from plan providers and doctors or other medical providers who are not plan providers before your membership in our Plan ends, neither we nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Customer Service to find out if your hospital care will be covered by our Plan. If you have any questions about leaving our Plan, please call us at Customer Service.

We cannot ask you to leave the Plan because of your health.

We *cannot* ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- **If you move out of the service area or are away from the service area for more than six months in a row.** If you plan to move or take a long trip, please call Customer Service to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you cannot remain a member of Fallon Senior Plan Premier. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). Section 2 gives more information about getting care when you are away from the service area.
- If you do *not* stay continuously enrolled in Medicare A and B.
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a one-calendar-month grace period during which you may pay the Plan premiums before your membership ends.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

12 Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the State(s) of Massachusetts may apply.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

13 Definition of Some Words Used in This Book

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or a Part D drug benefit, or payment for services or a Part D drug benefit you already received. You may also make a complaint if you disagree with a decision to stop services or drugs that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Part D Plan Sponsor must use when you ask for an appeal. Sections 9 and 10 explain about appeals, including the process involved in making an appeal.

Benefit period – For both our Plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually get during the stay determines whether you are considered an inpatient for SNF stays, but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both. (Section 2 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are getting inpatient services in the hospital (the type of care you actually receive in the hospital doesn't determine whether you are considered an inpatient in the hospital).

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,050 in covered drugs during the covered year. Please see Section 4 of this document.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount the plan may impose before services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a service.

Coverage Determination –A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The general term we use to mean all of the prescription drugs covered by our Plan.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 3.

Creditable Prescription Drug Coverage -Prescription drug coverage (for example, from an employer or union) that is expected to pay as much as standard Medicare prescription drug coverage

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Customer Service.

Disenroll or disenrollment – The process of ending your membership. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 11 tells about disenrollment.

Durable medical equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 2 tells about emergency services.

Evidence of coverage and disclosure information – This document along with your enrollment form, which explains your coverage, and what we must do, and explains your rights and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the Plan.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Grievance - A type of complaint you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 8 for more information about grievances.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period before your total Part D drug expenses have reached $4.050, including amounts you've paid and what our Plan has paid on your behalf.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

Medically necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization – Medicare Advantage Plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called "Part C." They provide all your Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (prescription drug) coverage.

Medicare Advantage Plan with Prescription Drug Coverage –A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan.

Medicare Health Plan – A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plans that are offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).
Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

"Medigap" (Medicare Supplement Insurance) Policy -- Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in the Original Medicare Plan. Medigap policies only work with the Original Medicare Plan.

Member (member of our Plan) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-plan provider or non-plan facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Non-plan providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by our Plan or Original Medicare.

Organization Determination - The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – Some people call it "traditional Medicare" or "fee-for-service" Medicare. The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 2.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs, see your formulary for a specific list of covered drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, and over-the-counter drugs were specifically excluded by Congress from the

standard prescription drug package (see Section 7 for a listing of these drugs). These drugs are not considered Part D drugs.

Plan provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**plan providers**" when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services.

Plan sponsor –The organization that administers your group plan. This is usually your employer.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or non-network providers. Member cost-sharing may be higher when plan benefits are received from non-network providers.

Primary Care Provider (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other plan provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 1 for information about how to contact the QIO in your state and Section 9 for information about making complaints to the QIO.

Quantity limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

Service area – Section 1 tells about our Plan's service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a Medicare Health Plan.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care – Section 2 explains about "urgently needed" services. These are different from emergency services.

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